CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Lathan Brown
Hearing dates:	26 - 30 May 2025, Dubbo Local Court
Date of findings:	7 August 2025
Place of findings:	Dubbo Local Court
Findings of:	Deputy State Coroner, Magistrate Devine
Catchwords:	CORONIAL LAW – Aboriginal death in custody, cause of death, timeliness of emergency response, adequacy of emergency response, health care whilst in custody, communication between Corrective Services and family members during medical emergency
File number:	2024/00008248
Representation:	Counsel Assisting: William de Mars, instructed by Claudia Hill (CSO) Michael Brown: Emma Parker, instructed by Tia Caldwell (ALS) Lois Mackay: Isaac Morrison and Tenika Vakauta (Legal Aid NSW) CSNSW: Jonathan Wilcox, instructed by Anastasia Poulios (DCJ) Justice Health: Simon Grey, instructed by Kate Hinchcliffe (Makinson d'Apice)
Findings:	**Identity of deceased**: Lathan Brown **Date of death**: 6 January 2024

Place of death: Orange Hospital ORANGE NSW 2800

Cause of death: Cardiac arrhythmia

Manner of death: Natural causes while in the lawful custody of Corrective Services NSW

Recommendations: To The Commissioner of Corrective Services NSW:

That consideration be given to adopting a procedure at Wellington Correctional Centre that would require at least one incoming and one outgoing officer to be present, so far as possible, in the J Block officers' station, during the handover period between A and C watches, in order to facilitate the timely response to knock-up calls requiring an urgent response.

That action be taken to investigate and, if appropriate, implement measures to improve the quality of the audio from knock-up calls heard in the monitor room at Wellington Correctional Centre, including if appropriate by restoring the availability of a functioning handset, and take steps to ensure that monitor room staff are aware of the available hardware for answering knock-up calls.

That COPP 13.2 be amended by the inclusion of a policy that addresses the following:

(a) A requirement for the Governor or OIC to delegate a sufficiently senior correctional officer or other staff member to liaise with the ECP in circumstances where the death of an

inmate transferred to a hospital may be imminent.

(b) The Governor or OIC or delegated officer must provide the inmate's Emergency Contact Person (ECP) with a contact name and telephone number of a medical professional at the hospital or medical facility to enable the ECP to have a point of contact with them for ongoing communication.

(c) The Governor or OIC or delegated officer being an ongoing point of contact for an inmate's ECP including in terms of any planned transfers.

(d) The Governor or OIC or delegate must otherwise facilitate contact and arrangements between hospital staff and the inmate's family.

Publication orders: Protected Information Orders apply to the evidence in this inquest. A copy of the orders made by Deputy State Coroner Pearce can be obtained from the Court Registry.

FINDINGS

Introduction

1 This is the inquest into the death of Lathan Brown who tragically died, aged 28, on 6 January 2024 at Orange Hospital. I will refer to Mr Brown by his first name, Lathan, as is preferred by his family.

2 At the time of his death, Lathan was in the lawful custody of Corrective Services NSW. He had been held on remand at Wellington Correctional Centre from 5 December 2023 until the day of his death, a period of around one month.

3 Lathan died as a consequence of a fatal heart arrythmia.

4 He was a proud Kamilaroi and Barkandji man, the eldest child of Michael Brown and Patricial Grainer, grandson of Lois Mackay and brother to Claudia, Mikey, Jade, Lane, Nash, Paris and Ricki-Lee. He was also an uncle and mate to many.

5 Lathan is missed by all those who loved and cared for him and I would like to begin these findings by expressing my sincere condolences to the family and friends of Lathan for their profound loss, particularly his grandmother, Lois and his father, Michael. It is important to acknowledge that they have endured a great tragedy in losing him.

6 It is also important to recognise that the coronial process represents an intrusion by the State into what is a profoundly traumatic event in the lives of family members and that an unfortunate aspect of the coronial process is that it can require a family to re-live distressing memories. That was painfully obvious during the inquest, particularly in the moving and powerful family statements made upon conclusion of the evidence by Lathan's father and sister, Claudia.

7 In those statements they shared with the Court a little of Lathan's personality and I learnt about the qualities that made him unique and much loved. In

particular, I learnt of his fighting spirit, his similarities to his father, his participation in cricket and footy, his love for rap music and culture and the close bonds he had with family and friends reaching across 3 states. It was my honour to be introduced to Lathan through Michael and Claudia and the video that they prepared about him. I will say something more about Lathan's background shortly.

8 I also want to record my utmost respect for Lathan's family. Their participation in these proceedings, as difficult as it was, showed the strength of their ties to one another, their fortitude, their grace and their quiet dignity. It is obvious to me they wanted to understand the full circumstances of Lathan's death, but also wanted to be part of any positive change that could arise from his passing.

Legal Framework

9 Under the *Coroners Act* 2009 (the Act), a Coroner has the responsibility to investigate all reportable deaths. Pursuant to sections 23 and 27 of the Act, when a person dies in custody it is mandatory that an inquest is held and the inquest must be conducted by a senior coroner.

10 This is because when a person is detained in custody the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate.

11 The primary purpose of a coronial inquest is to make formal findings as to the following five aspects of a death pursuant to s81 of the Act: (1) the identity of the person who died, (2) the date they died, (3) the place they died, and what was (4) the cause and (5) the manner of that person's death. The inquest investigates the facts and circumstances of a death, places them on the public record, and in certain cases will examine recommendations that could be made to prevent similar deaths in the future.

12 An inquest is not a forum where a Coroner sets out to prove any allegation or proposition or attribute blame or responsibility. Rather, an inquest is an inquisitorial exercise in fact finding, aimed at discovering what occurred, and it is this principle that steers the approach taken by a Coroner in evidentiary and procedural matters. It is also an opportunity for families to air concerns they have and to have relevant fears or suspicions allayed.

13 Over and above the requirements of s81, because Lathan was a First Nations person who died in custody both Coronial Practice Note 3 (concerning the case management of mandatory inquests), and the State Coroner's First Nations Protocol are applicable. This means that as a Coroner I must:

(1) Ensure, as far as possible, that the full facts are brought to light;

(2) Ensure accountability by identifying any systems failures or conduct warranting criticism and recommend remedial action for any such matters;

(3) Reassure the family and friends of Lathan that lessons learned from a death in custody may save lives in the future; and

(4) Deliver these findings promptly.

14 Further, the inquest had to be conducted in a culturally sensitive and appropriate manner, including by adhering to any cultural considerations raised by the family; and legal representatives were obliged to conduct themselves in a manner that was respectful of the deceased's family and mindful of the grief and loss experienced by them.

15 As I indicated upon conclusion of the oral evidence, I am pleased to say that those appearing at this inquest conducted themselves consistently with these requirements and in the finest traditions of the legal profession.

The Context for this Inquest

16 Before turning to the particular facts of Lathan's death, it is necessary to place his death whilst in custody in a wider context.

17 Every First Nations death in custody represents the loss of a valued individual, family and community member, and should be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations Peoples.

18 Furthermore, Aboriginal and Torres Strait Islander people are notoriously over-represented within NSW's prison population and consequently there are a disturbing number of Aboriginal deaths in custody. There can be no argument that First Nations people continue to experience significant disadvantage and poorer health outcomes across the board compared to the broader population.

19 Consistent with these observations, the material tendered to this inquest includes a March 2021 report "Health Services in NSW Correctional Facilities" from the Inspector of Custodial Services. It notes that in 2021 62% of prisoners at Wellington Correctional Centre's maximum security facility, where Lathan was being held, were Aboriginal, at that stage the second highest proportion in the state after Tamworth.

The evidence

20 A coronial investigation precedes an inquest. During the investigation considerable evidence, in form of witness statements, expert reports, business records, government policies, photographic evidence and more are obtained by, and provided to, the Coroner. A report as to the cause of death (a post-mortem report) is provided by a forensic pathologist.

21 In the case of the investigation into Lathan's death, a five volume brief of evidence complied by the Officer in Charge of the coronial investigation, Detective Senior Constable (DSC) Tom Magann, and supplemented by the Assisting team, was tendered to the Court and became Exhibits 1- 6.

22 I thank the Officer in Charge of the Investigation for the thoroughness of his investigation because, to a very considerable extent, it brings to light the full facts surrounding Lathan's death.

23 The inquest also heard oral evidence over 5 days. The Court heard from not only those involved in Lathan's management and care whilst in custody but also from the Officer in Charge, Lathan's cellmate and an expert cardiologist. This evidence shone further light on the issues.

24 Given the huge volume of material before the Court, it is not possible (nor desirable) to refer specifically to all the available evidence but I want to assure Lathan's family that I have had the opportunity to thoroughly review and consider the entirety of the material and I have done so with the benefit of written submissions from all interested persons and I will touch on those aspects of the evidence that I consider most significant.

25 In deciding what matters to touch on I have also been guided by an Issues List that was circulated amongst the legal representatives appearing in the matter and which refers to the following matters:

(1) What was the cause of Lathan's death?

(2) Was the death preventable?

(3) In any event, was the timeliness of the emergency response to the knock up call reasonable?

(4) Was the emergency response at the Correctional Centre adequate in other respects?

(5) Was the health care provided to Lathan in the period following his entry into Corrective Services custody on 5 December 2023 adequate and in compliance with policy and should any underlying condition have been detected prior to his death?

(6) In relation to the medical emergency on 6 January 2024, was communication by Corrective Services Officers with family members adequate?

(7) Are there any recommendations that should be made?

26 In relation to non-contentious factual matters and issues I have also had the considerable assistance of Counsel Assisting and I have drawn extensively from his submissions in these findings. I am enormously grateful to Counsel Assisting and the instructing team for their assistance in this regard.

Lathan's background

27 Lathan was the first child of his parents Michael Brown and Patricial Grainer, who lived in Bourke at the time of Lathan's birth. Lathan was premature and spent some weeks in hospital in Sydney and Dubbo at the time of his birth. Lathan has seven siblings: Claudia, Mikey, Jade, Lane, Nash, Paris and Ricki Lee.

28 Up until the age of around 18, Lathan spent most of his life in Bourke, finishing Year 10 at Bourke High School. His parents separated at around the time Lathan started going to school, and so from the age of 4 or 5, Lathan and his sister Claudia lived with their maternal grandma, Lois Mackay. Michael had to frequently travel away from Bourke for his work and Patricia sometimes had challenges related to her health and substance use.

29 Michael recalls that Lathan enjoyed playing sports and was passionate about rap music. However, he says that he struggled with schoolwork and in his teen years he started smoking cannabis at times.

30 When Lathan was around 18, his mother moved to Narromine for dialysis treatment. Lathan then also moved to Narromine with Lois and Claudia. Lathan did some work from time to time working in shearing sheds but it appears that he was increasingly using illicit drugs, particularly after his mother passed away in 2019.

31 Lathan was of small stature and, it appears, quiet demeanour, but was known to possess a good sense of humour. He is remembered by those that knew him best for reasons including his creativity and warmth.

32 Lathan's contact with the criminal justice system involved relatively minor matters arising from his drug use. In September 2023 he was placed on community correction orders relating to shoplifting matters. In early December 2023 he was arrested and charged with further stealing matters. On 5 December he was refused bail at Dubbo Local Court. He was remanded in custody and taken to Wellington Correctional Centre. At the age of 28 this was his first and only time spent in adult Correctional Services custody.

33 Prior to the day of his death, Lathan was not known to have any underlying medical condition that might lead to his sudden demise.

Lathan's time in Wellington Correctional Centre

34 Lathan entered the Correctional Centre on 5 December 2023. On the evening of his entry Lathan underwent a health Reception Screening Assessment that was conducted by a Justice Health nurse, Ms Jeannette Byrne (formerly Murphy). In oral evidence Ms Byrne explained that she had no specific recollection of Lathan's screening.

35 The screening was comprehensive in nature. It included obtaining Lathan's "vitals", taking various measurements, administering a urinalysis test (not for drugs and alcohol) and taking a history from him on a variety of health issues. From that assessment key information was then provided to Corrective Services.

36 The purpose of the assessment is to alert Corrective Services to health issues an inmate may have. It is also relevant to an inmate's cell placement.

37 In Lathan's case, Ms Byrne agreed that she had recorded his weight as 48kg, his Body Mass Index at 16kg sqm and his waist circumference as 54cm. She agreed that the BMI reading is abnormally low and concerning for malnutrition

and would have been of concern to her if correct. She further agreed that a follow-up or referral to a GP about his weight, whilst not done, would have been appropriate in the circumstances of such results.

38 If Lathan's weight and BMI was correctly recorded, the Court heard evidence from A/Prof Adams (see further below) that the measurements represent "an abnormally low weight and would be concerning for malnutrition with the World Health Organisation classifying less than 18.5 as underweight and less than 16.5 as severely underweight. He further stated people with malnutrition have a higher rate of sudden unexpected death and that because malnutrition can affect cellular electrolyte levels (and thus normal heart contraction) it could have played a role in the development of Lathan's subsequent cardiac arrythmia.

39 It follows from A/Prof Adams' and Ms Byrne's own evidence that if she *correctly recorded* Lathan's weight and/or BMI but failed to note any issues regarding that or failed to refer him to the GP that *would* be of concern. The submission of Justice Health that I would not come to that conclusion is based on a non sequitur.

40 Having said that, in a "New Inmate Lodgement" form completed just 24 hours earlier at Dubbo courthouse cells, Lathan's weight was recorded as being 60kg and at autopsy, Lathan's weight was noted to be 64kg with a "normal" BMI of 22.4.

41 Given (a) Ms Byrne did not note any issues regarding Lathan's weight or refer him to a GP, (b) her concession in cross-examination that she may have inaccurately recorded his weight and (c) the marked disparity between her recordings and the recordings made 24 hours earlier and at the time of autopsy, *I am satisfied that Ms Byrne has inaccurately recorded the relevant data and that she did not gain the impression he was 48kg*.

42 Whilst that is a concern in itself, I am satisfied there was not a failure to recognise an aspect of Lathan's health that should have been reviewed. I am

further satisfied that possible rapid weight gain whilst in custody is not an issue that arises in Lathan's death.

43 Outside of Lathan's history of drug use, Ms Byrne's assessment did not give rise to any particular health concerns being identified. It followed that Lathan was referred to a drug health nurse and was later placed on a waiting list to see an Aboriginal Health Worker. He subsequently saw Registered Nurse Jessica Goodchild for drug and alcohol education on 4 January 2024.

44 On 6 December 2023 an "Intake screening questionnaire" was completed by Assessor Raearne Wright. Lathan is described in that document as polite and respectful. It is noted that it was his first time in custody. It is further noted Lathan denied any concerns for his safety or had thoughts of self-harm. He indicated a ten-year history of ice and cannabis use.

45 On 12 December 2023 Corrective Services records note that a phone call was facilitated so that Lathan could speak with his grandmother, Lois Mackay. The call was noted to be positive.

46 As Lathan was an unsentenced prisoner, he did not receive any "Custodial Case Management".

47 Starting on 19 December, Lathan worked in the Correctional Centre's bakery as a "pie flipper". A report in relation to his work describes him as a "quiet inmate who kept to himself".

48 Lathan was housed in cell 81, in C Pod at the Correctional Centre. The cell was about 2m wide by 3 or 4ms long and consisted of two beds on either side of the cell, a small toilet and shower area that was close to the entry door and a small bench. He shared cell 81 with another inmate, David Riley. They shared the cell for two weeks and appeared to get on well.

The events of 6 January 2024

49 6 January 2024 was a Saturday. Gaol routine involved inmates being released from their cells into the communal pod area sometime after 8am in the morning. Inmates had access to an indoor communal area, and from there they could access an exercise yard area, where they would sometimes play touch football and could also use a basketball hoop.

50 Lathan can be seen in the CCTV footage that covers the C Pod area throughout the day, at times engaged in playing touch football and basketball.

51 Shortly after 3pm inmates were locked into their cells until the next morning. Lathan and his cellmate were locked into cell 81 at 3.07pm. The two officers on duty in C Pod left the Pod at about 3.10pm.

52 Officers do not remain stationed in individual Pods after lock-in. During C and B watches, the evening and overnight shifts, inmates are left to raise urgent matters with Correctional Officers by use of the intercom in their cell. The use of the intercom is referred to as a "knock up" call.

53 At 3.41pm, just over half an hour after being locked in, Lathan's cell mate David Riley made a knock up call that was answered in the gaol's monitor room.

54 An emergency response involving correctional officers and Justice Health nurses followed.

55 When interviewed about the matter later that day, Mr Riley told investigators that Lathan ate his evening meal shortly after lock in and that he waited until Lathan had eaten before taking a shower. Showers run for about 5 minutes and towards the end of his shower he heard Lathan coughing. Upon exiting the shower he saw that Lathan was lying down, was not responding to him and did not appear to be breathing.

__The Emergency Response__

56 Mr Riley's first words in the knock up call were:

Hello, um, my name is David Riley. I'm in Pod C. Um, I just, uh, I think, uh, something, like, I don't know what happened to my cell mate. I just need the ambulance or someone down here, straightaway. Like, you know? Nurse or something. He, he's stopped breathing.

57 Soon thereafter the officer who received the call, CO Jade Miller, called for a "*medical response*" by radio. As a result, a number of Correctional Officers and two Justice Health nurses made their way to Cell 81.

58 There don't appear to have been any officers in the immediate vicinity of C Pod at the time (due to the A Watch officers having completed their "lock in" duties by the time of the emergency response) but the body worn video recorded by several of the officers suggests that the officers and nurses who attended Cell 81 appear to have made their way to the cell with haste.

59 The first two officers arrived at the cell at 3.44pm, just under 3 minutes after the knock up call was answered. Bearing in mind that the "medical response" call was not made until 40 seconds or more after the knock up call was first received, it appears that it took officers a little over 2 minutes to reach the cell. There was a further delay of around 28 seconds before officers entered the cell, as they sought to communicate with Mr Riley and explain that he had to stay at the back of the cell before they would enter. In all, 3 minutes and 24 seconds elapsed between the knock up call first being answered and officers entering the cell.

60 Once they had entered, body worn footage indicates that officers rapidly commenced CPR.

61 Shortly after the arrival of officers in the cell, at 3.46pm, a call was made by a correctional officer to 000, asking for the attendance of ambulance services.

62 Twenty seconds after their entry a third officer (CO Steve Fessey) arrived with a defibrillator that he had obtained from an area of the jail called “J block”. The defibrillator pad was attached to Lathan’s chest and about a minute and a half after officer Fessey’s arrival, it delivered a shock.

63 Continuing efforts were made to revive Lathan by Justice Health Nurses and Correctional officers, by CPR and use of oxygen, until the arrival of the first paramedic at 4.04pm.

64 An ambulance departed the jail at 4.43pm, by which time a pulse had been restored to Lathan, though he remained unconscious and could not breathe on his own. His care was handed over to Doctors at Wellington Hospital at 4.53pm.

Wellington Hospital

65 A statement provided by Dr Gregory Button summarises the treatment that Lathan received at Wellington Hospital. He observes that Lathan was extremely unwell when he arrived and that:

(1) Although he had a pulse, he was observed by paramedics to be completely unresponsive with no signs of life apart from a heartbeat.

(2) There was a chance Lathan had suffered an irreversible hypoxic brain injury prior to the return to spontaneous circulation (ROSC), which is measured by the presence of a heartbeat.

(3) Lathan had arrested at least twice prior to his arrival in ED and never regained consciousness at any time. He was not breathing spontaneously and was being ventilated manually.

66 Dr Button notes that Wellington Hospital is a small rural multi-purpose health service. It provides inpatient care for low acuity health issues and recovery / rehabilitation. It has a small emergency department (ED) that is managed by general ward nursing staff and a local GP, Dr Green.

67 Dr Green arranged a "vCare" consultation, vCare being a virtual advisory service that provides 24/7 assistance to rural hospitals to manage critically ill patients. At 5.15pm a vCare clinicians' conference was convened that involved a number of experienced specialists in both Sydney and Dubbo.

68 At 6.15pm it was agreed that Lathan would require "retrieval", with a plan that he would be taken to Dubbo Base Hospital. The retrieval team arrived at Wellington at 7.03pm and Lathan continued to receive intensive treatment from the retrieval clinicians.

69 During continued treatment and monitoring at Wellington, Lathan's condition did not improve (he became hypoxic and hypotensive and had several further cardiac arrests). It appears that shortly before 9pm a decision was made that Lathan would be transported to Orange Hospital rather than Dubbo.

Orange Hospital

70 At around 9.30pm, Doctors at Orange Hospital were told to prepare for Lathan's arrival. Lathan left Wellington Hospital by helicopter at 9.40pm and arrived in Orange soon after 10pm. By this stage his condition had deteriorated further still. He received ongoing intensive treatment to improve his condition, without success, and at 11.10 pm a decision was made in consultation between the various specialists involved, to cease resuscitation efforts. Infusions and ventilation was ceased and Lathan passed away in the Emergency Department at 11.15pm.

Issue: What was the cause of Lathan's Death?

71 During the emergency response and while being treated at Hospital, a concern developed that Lathan's condition may have been brought about by the use of an illicit drug. The suspicion appears to have arisen out of an initial comment made by Mr Riley in the knock up call that he made, that "It might be over drugs or something, I don't know" and that Lathan may have had a "fit".

72 There is ultimately *no evidence to support the suspicion,* and I note the following 5 matters on this issue.

73 Firstly, Mr Riley agreed in oral evidence that he had never seen Lathan use drugs and that he had no particular understanding or information suggesting that Lathan had consumed a drug. To the contrary, he just assumed Lathan used drugs because, whilst he was a “good eater”, he was skinny. He also explained that he used the term “fit” not as gaol slang but in reference to Lathan “twitching” and that he thought Lathan may have been having an epileptic seizure.

74 As it happens, Mr Riley’s suspicion that Lathan was having an epileptic fit was based on another mistaken assumption: that Lathan was a “two out” inmate (meaning he was to be housed with another inmate, and not on his own) because Lathan had some medical condition unknown to him whereas, in fact, Lathan’s “two out” status arose from the fact that he was serving his first period of time in Corrective Services NSW custody.

75 Secondly, DSC Magann spoke of police being aware of the suspicion Lathan had had a drug overdose from the outset of their investigation and of police searching (a) Lathan’s cell, (b) the cell Mr Riley was moved to during the emergency response, (c) the person of Mr Riley and (d) other inmates. His evidence was emphatic: he found nothing whatsoever to suggest Lathan had taken any illicit substances.

76 Thirdly, although clarification of this matter with Mr Riley was sought at an early stage by SCO Davern, the initial mistaken suspicion appears to have persisted throughout the day, including with doctors treating Lathan. For eg, notes made at Orange Base Hospital include a reference to there apparently having been a “hotshot of an unknown substance” and an *incorrect* reference to a syringe having been found.

77 Mr Riley’s general reference to “drugs” and use of the word “fit” appears to have resulted in some of the officers hearing the knock up call in the monitor room

assuming that use of an illicit substance was the likely cause of the medical event. For eg in her report made later that day, officer Jade Miller *mistakenly* recalled the words used by Mr Riley to be “he had a fit and I think he’s had a shot or overdosing”. Officer Ryan Alexander’s report also made on the day states (again *mistakenly*) that Mr Riley had said of Lathan “I think he’s had a shot of drugs”.

78 Fourthly, Dr Lorraine du Toit-Prinsloo, Forensic Pathologist, completed a thorough forensic examination of Lathan’s body on 11 January 2024 at the Forensic Medicine Centre, Lidcombe and prepared a post-mortem report. In that she makes clear she was aware of the concern and recommended Lathan’s cause of death be left as unascertained. Importantly, however, she noted:

(1) Toxicology conducted on *ante*mortem blood samples detected no alcohol or illicit substances commonly screened for.

(2) Toxicology conducted on *post*-mortem samples detected no alcohol in the blood.

(3) The only drugs detected were those known to have been administered for the purposes of the emergency treatment

(4) The only significant macroscopic findings were the features of mitral valve prolapse she observed.

(5) There is an increased risk of arrythmia and sudden death in some instances of mitral valve prolapse.

(6) In the absence of any other underlying cause of death, consideration should be given to Lathan having had a sudden cardiac death that could either be related to the underlying mitral valve prolapse or from a channelopathy.

79 In a follow-up report responding to particular issues Dr du-Toit Prinsloo expressed the view that the administration of naloxone to Lathan during the emergency response while at Wellington Correctional Centre did not contribute to his cause of death.

80 Fifthly, Associate Professor Mark Adams, a specialist cardiologist, also considered the concern and prepared a report to assist the Court in determining Lathan's cause of death. Neither his expertise nor his conclusions were challenged.

81 He concluded that the most likely cause of Lathan's death was a sudden cardiac death due to an arrhythmia such as ventricular tachycardia (VT) or ventricular fibrillation (VF).

82 He told the inquest that *the autopsy and toxicology results rule out all other causes of sudden unexpected death other than arrhythmia* and that if Lathan was only able to play touch football in a limited way on the day of his death and reported feeling unwell that was certainly consistent with someone who had developed a sudden reduction in heart capacity consistent with an arrhythmia.

83 He considered that the fatal arrhythmia was probably related to Lathan having a mitral valve prolapse, a relatively common condition where the flaps of the mitral valve can bulge backwards during contraction of the heart and of the over-representation of people with this condition in cases of sudden cardiac death. In fact, he considered this not to be an unusual finding, noting a study that concluded that "no pertinent findings at autopsy account for around 41% of sudden deaths in people under the age of 35" and that it is thought that "the vast majority of these deaths are due to arrhythmias".

84 In his oral evidence, A/Prof Adams explained his reasoning why this was the most likely cause of Lathan's death. He said that if Lathan had died of an overdose or by drowning or by coronary disease, indeed in most cases of sudden death, the cause will generally show up in the post-mortem (i.e. there will be a positive finding in toxicology results, or there will be water in the lungs

or evidence of myocarditis etc) but Lathan had nothing to show his cause of death on post-mortem examination. In fact, the only thing that stood out was his prolapsed mitral valve.

85 A/Prof Adams could not, however, exclude the possibility that one of a number of other conditions or syndromes (that he broadly described in oral evidence as occurring at a molecular level in the heart and that aren't visible at autopsy) could have been the underlying cause of the fatal arrhythmia.

86 Taking all these matters into account, I am comfortably satisfied that Lathan's death was not suspicious and did not arise from the use or administration of any drug. Rather, it was the consequence of a fatal heart arrythmia. While sudden and unexpected, the death was the result of natural causes. While it is suspected that Lathan's mitral valve prolapse, detected at autopsy, was the cause of the arrhythmia, the evidence is not sufficient to clearly determine this as the condition giving rise to the arrhythmia, as opposed to other possible underlying natural causes that were spoken of by A/Prof Adams.

87 No-one made a submission against these conclusions, and it does not appear that the treatment Lathan received was adversely affected by any incorrect understanding by those providing treatment to him.

Issue: Was the timeliness of the emergency response to the knock up call reasonable?

88 The following table reflects the precise timeframe for officers to respond to Mr Riley's knock up call:

Time (pm)	Event – As seen on CCTV Camera 301 (and linked to knock up call timing)
3.40.34	Approximate time David Riley initiates "Knock-up" call
3.41.04	Knock up call forwarded to Monitor Room: 3.41.15: Riley says "need an ambulance"

	3.41.21: Riley says cellmate has “stopped breathing” 3.41.41: CO Miller “Righto, we’ll get the nurses down”
3.41.41- 3.42.38	No communication between CO Miller and inmate Riley. During this period CO Miller “got on the radio and called a medical response to C Pod, cell 81”, saying words to the effect of "*There's a non-responsive inmate*".
3.42.38	CO Miller asks Riley “Is he breathing at all?”. She provides further advice to inmate Riley, prior to the arrival of officers
3.44.00	First two responding officers arrive outside Cell 81
3.44.28	Door is opened (28 second delay involved officer instructing inmate Riley to back away from the door prior to it being opened, and Riley having difficulty understanding)
3.44.48	CO Fessey arrives at the Cell 81, having obtained the AED (Defibrillator)
3.44.52	A fourth officer arrives and enters cell 81
3.44.57	Inmate Riley is escorted out of the Cell by CO Mohapp
3.45.03	A fifth officer arrives
3.45.35	A sixth officer arrives, followed by JH Nurse
3.45.54	A seventh officer arrives, carrying a large red medical bag
3.46.02	Second JH Nurse arrives, pushing a cart, along with an eighth CO
3:46.16	Call made by CO Alexander to 000 is received by NSW Ambulance Service
3.46.22	Automated voice from AED can be heard – “*shock delivered*”, after which Lathan is moved to the floor

3.47.02	The second JH nurse enters Cell 81, having spent a short period doing something in relation to oxygen tank and mask, which she then takes into cell

89 A/Prof Adams' conclusion about the responses of Correctional Centre staff is that they were appropriate and adequate. In saying that A/Prof Adams notes:

(1) The time it took the Correctional Centre to respond and commence CPR was as good as was practically possible and importantly the time from notification until a defibrillator was attached was relatively short. This is *the* critical factor in the chances of survival.

(2) An ambulance was called for within a few minutes.

90 Paul Sheehan, Principal Investigator with Corrective Services NSW Investigations also prepared a Serious Incident Report regarding appropriateness of the emergency response. He concluded that Lathan was managed in accordance with Corrective Services NSW policies and procedures prior to his death and that the response activities were conducted swiftly in accordance with the same. He said he considered the current policies and procedures relevant to Lathan's death were appropriate.

91 I accept the conclusions of A/Prof Adams and Mr Sheehan that individual Corrective Services officers involved in the response conducted their responsibilities in a timely manner. Indeed, the first responding correctional officers can be seen to attend to Cell 81 in Pod C with haste. One of those three officers (Officer Fessey) collected that defibrillator from J Block on his way, and arrived with the device only 20 seconds after the cell door was opened. The two Justice Health nurses on duty attended soon thereafter with relevant equipment.

92 I further accept the submission that the actions of any individuals did not unreasonably delay the time taken to respond to Mr Riley's knock up call.

93 Having said that, in the context of A/Prof Adams' evidence that the time taken for a defibrillator to be deployed is *the* critical factor in the chances of survival, it is worth noting the following evidence:

(1) The "shifts" at Wellington Correctional Centre are as follows:

(2) Mr Riley's knock up call was made during the and approximately 30 minutes after C Pod inmates had been "locked in" till morning.

(3) As a result, the officers who first responded to the emergency were not in the immediate vicinity of C Pod at the time. Rather, they were in the in the process of "gearing up" for their forthcoming shift.

(4) Getting from the key watch area to C Pod involves passing through 5 or 6 doors or gates, involving a combination of keys and monitored controlled locks. The distance from the key watch area to C Block appears to be in the vicinity of 250 to 300 metres.

(5) By contrast Senior Assistant Superintendent Bolden estimated it to be 120-150 metres from C Pod. Access from J Block to C pod involves going through 1 door, then "a gate at top of main accommodation area is always open so (it's) just matter of walking through and then the airlocked doors to C pod."

(6) Officer Miller gave evidence that defibrillators are located in an area outside the key watch area, which is outside the jail, and in J Block.

(7) In oral evidence Officer Miller indicated that she was not aware of any expectation or policy whereby J Block is supposed to be manned during the changeover period. She agreed that it may have been the case that the knock up call would have first gone to J block before diverting to the Monitor room because it went unanswered. Officer Miller also gave evidence that once muster is done, officers make their way out of J Block.

(8) Officer Alexander, who was in the monitor room with Officer Miller, gave evidence that once he heard on the knock up that a response was required, he called J Block to see if there was an officer there who could respond. He did this because it was closest to C Pod and an officer there could respond more quickly. It was also where the defibrillator was located. He was not aware of any policy or practice requiring the presence of an officer in J Block during the changeover period.

(9) Officer Serone gave evidence that outside the "[redacted] [redacted] J Block was otherwise regarded as a "24 hour post".

(10) SAS Bolden gave evidence that she was in J Block at the time of the knock up call but did not hear it as she was not in the officers post area of J Block. She did not appear to suggest that there was any policy whereby an officer was required to stay in the J Block officers post during changeover but indicated that normally there would be an officer "staying back" or "coming in early". She indicated that it was desirable for that to be the case so that an officer could "respond to an incident".

94 What flows from the totality of the matters referred to in [93], is that whilst it would not have made a difference in Lathan's case, the response time between the knock up call and cell entry (nearly 4 minutes) could have been considerably shorter had there been officers in position at J Block at the time of the knock up call. Potentially, the 30 to 40 second delay that results when no one is in position at J Block to hear the knock up call would have been saved. In addition, the

defibrillator would have been at hand and the route to C Pod would have been significantly shorter and not have involved the opening of as many gates and doors.

95 Counsel Assisting submitted that in such circumstances a recommendation to Corrective Services NSW could be made in these terms:

> That consideration be given to adopting a procedure at Wellington Correctional Centre that would require at least one incoming and one outgoing officer to be present, so far as possible, in the J Block officers' station, during the handover period between A and C watches, in order to facilitate the timely response to knock-up calls requiring an urgent response.

96 That submission was joined in by Lathan's family and adopted by Commissioner of Corrective Services NSW (with the reservation that it would need to be discussed with local unions and, if accepted, would need to be included in the Post Duties of the identified post).

97 Lathan's grandmother further submitted that consideration should be given to placing additional defibrillator units closer to inmate pods (for eg inside the officers' stations in the pods themselves).

98 The Commissioner has recognised the strength of that submission and has indicated that Wellington Correctional Centre will investigate the purchase and placement of additional defibrillator units in locations closer to inmate accommodation.

Issue: Was the emergency response at the Correctional Centre adequate in other respects?

99 It was not submitted by Counsel Assisting or Lathan's family members that the emergency response would be regarded as "inadequate" in relation to other respects.

100 It was clear at the inquest however, that communication between Corrective Services officers and Lathan's family during the emergency response was a fundamental concern to Lathan's family and this issue was explored in some detail.

101 A further 5 matters emerge from submissions that might appropriately be the referred to in considering the response. Those 5 further matters are:

(1) The question of ambulance access to Lathan;

(2) The audio quality of the knock up call;

(3) The number of officers in Lathan's cell;

(4) The use of restraints on Lathan; and

(5) The possibility of Lathan's early release from custody.

102 As the communication between Corrective Services officers and Lathan's family during the emergency response was identified as a separate issue in the inquest I will deal with these 5 other matters firstly.

Ambulance Access to Wellington Correctional Centre

103 Evidence before the inquest highlighted the fact that ambulance entry to a secure correctional facility such as Wellington is not straightforward. It is understandable, given the nature of the institution, that security requirements involving multiple gate opening procedures are necessary.

104 In the course of the response to the 000 call made at 3.46pm, three separate paramedic "units" responded and attended at the centre. The first paramedic (a single officer, Dean Alchin) was "on scene" at 4:04pm, followed by a second unit (two paramedics in an ambulance) at 4:07pm. A third unit (paramedics Scott Ferrari and Jasmine McPherson in a second ambulance) arrived at the front gates at 4.14pm, but were not able to access C Pod until 4.23pm.

105 The single paramedic who first arrived described his transition through the "main security section" at the correctional centre as "rapid", stating:

> "they got me through pretty quick without having to stop for the usual security checking. I would estimate the time from the boom gate at the road to me arriving to patient to have been about 3 to 4 minutes. The staff were prepared and were posted in key locations to guide me around to the cell block without delay."

106 Contrasting observations were made by paramedics in the two ambulances that followed. Paramedic Glen Flanagan, in the first of the two ambulances, observed that

> "(t)he one thing that seems to be an issue with Correctional Centres is the time it takes to get through the airlock gates and then to the actual cells. In my experience this process always takes at least 5 minutes."

Paramedic Scott Ferrari, arriving in the second ambulance observed:

> "The only issue I identified which is an issue with all correctional centres, is the time it takes to get access to the patient once you arrive on scene. There always seems to be a delay from the time we arrive at the front gate until the time we get to the patient. On this occasion it was 9 minutes."

107 The involvement of correctional officers in providing access to ambulances was explored to some degree in evidence, though not comprehensively. I accept the submission of Counsel Assisting and the Commissioner that it is beyond the scope of this inquest to make any criticisms or recommendations about communication between Corrective Services NSW and NSW Ambulance but note the following matters arise on the evidence before me:

(1) It is apparent that in advance of the arrival of the first unit, efforts were made to have officers posted to assist with the required access through

the various gates that was necessary to reach C Pod. Although access for the first two units took in the vicinity of 3-5 minutes, it appears that this was not excessive given the security logistics involved. The entry time of 9 minutes for the third unit seems to have involved *some* delay.

(2) There is evidence before me that NSW Ambulance gave advance notice to Wellington Correctional Centre of the arrival of the first two (but not the third ambulance). This *might* have impacted on Wellington Correctional Centre staff preparation for its arrival including proactively stationing themselves for the ambulance as the Commissioner submitted.

(3) In all the circumstances, it is not suggested that the delay caused any inadequacy to the emergency response, given that two units were already on scene and assisting.

(4) Again, while not critical of correctional officers providing access in this instance, it is notable that paramedics from two of the crews express concerns about the time it takes to access inmates more generally when attending correctional centres and that page 1 of Custodial Operations Policy and Procedures 13.2 states:

> "NSW Ambulance Service (NSWAS) and JH&FMHN personnel must be given *unhindered* access to correctional centres when they respond to medical emergencies. NSWAS and JH&FMHN must be escorted through correctional centres to ensure ease of access and to provide assistance with moving medical equipment through doors and gates". (emphasis added)

Knock up Call Audio Quality

108 About the knock up call audio quality, Officer Miller observed that "the knock up intercom is really hard to hear, it is very echoey and cuts out the conversation if the button is pressed." She further observed:

> "There is a phone handpiece in the monitor room that you can pick up instead to answer knock ups but since the mice plague two or three years ago it was not reconnected after the damage to the centre was repaired. I don't know why it wasn't re connected because it gets rid of the cutting out of the knock up calls caused by pressing the intercom button to transmit."

109 In her oral evidence officer Miller confirmed this to be the case and further observed that the handpiece has still not been reconnected. It was established that the mouse plague had caused the closure of WCC in 2021, and that it was reopened to inmates in March 2022.

110 While I accept the Commissioner's submission that the miscommunication between Mr Riley and Officer Miller appears to have arisen primarily from what Mr Riley said rather than Officer Miller not being able to hear him properly, she clearly had some difficulties at a critical time and this inquest provides an opportunity to address the audio quality of knock up calls at WCC in case it impedes any future calls and/or responses.

111 I further note the Commissioner's concession that on Officer Miller's evidence the purpose of the handset in taking calls is somewhat unclear and as such the Commissioner would support a recommendation on this topic.

112 The recommendation proposed by Counsel Assisting (and supported by Lathan's family) on this issue is as follows:

> That action be taken to investigate and implement measures to improve the quality of the audio from knock-up calls heard in the monitor room at Wellington Correctional Centre, including if appropriate by restoring the availability of a functioning handset.

113 The Commissioner supports the recommendation with some slight amendments (those amendments are underlined):

> That action be taken to investigate and, if appropriate, implement measures to improve the quality of the audio from knock-up calls heard in the monitor room at Wellington Correctional Centre, including if appropriate by restoring the availability of a functioning handset, and take steps to ensure that monitor room staff are aware of the available hardware for answering knock-up calls.

114 I accept the changes proposed by the Commissioner and adopt this as a final recommendation.

The Number of Officers in Lathan's Cell

115 Lathan's grandmother, Ms Mackay raised this as an issue noting that the body worn video of Officer Brodhi Avis shows, at times, there were as many as seven people (both correctional officer and Justice Health nurses) in Lathan's cell at the same time during the emergency response. The cell, as already observed, was quite small.

116 According to Officer Avis, Lathan was moved twice; initially closer to the cell door (whilst CPR was performed by correctional and Justice Health staff) and then into the storage room in the next cell (at the request of ambulance staff). On each occasion Officer Avis states Lathan was moved so that those treating him could free up a little more space for that to happen.

117 The Commissioner makes the point that the small size of the cell constrained ambulance officers, and this was unrelated to how many persons were in the cell at the time (for eg there was fixed furniture and Lathan needed to be put on a stretcher) and that Lathan was moved to the storage room to ensure his privacy whilst emergency treatment was provided.

118 Ms Mackay did not submit that the number of officers in Lathan's cell compromised the level of care he received. To the contrary, she accepted that a number of officers were needed to provide compressions and oxygen to Lathan in the context of the emergency response and submitted it could merely

be noted if the emergency response procedures at Wellington Correctional Centre were reviewed at a later time.

119 Given there is no medical evidence critical of this aspect of the emergency response, the limited exploration of the issue during the inquest and the similarly limited submission about it, I need not make any further observations about the number of officers in Lathan's cell.

The Use of Restraints

120 Evidence before the inquest highlighted the fact that the use of restraints on inmates on medical escort is another matter that is not straightforward. That again is understandable given the security requirements for inmates classified as maximum security (as Lathan was because of his status as an unsentenced inmate) and the need to ensure that restraint does not interfere with treatment.

121 Given the sensitivity of this issue for Lathan's family, it is important to state at the outset that *there is no evidence whatsoever of any restraints being used on Lathan at any time* during his medical emergency. In fact, the body worn video of Officer Avis that shows Lathan being loaded into the ambulance, the evidence of Officer Mullen and the evidence of Officer Cubillo positively establishes that he was not restrained at any time.

122 [redacted]

123 Having said that, Ms Mackay submitted that in circumstances where Lathan was either on life support or deceased, the evidence of Officer Cubillo (that Wellington Correctional Centre Officers discussed leaving their leaving their

restraints for relieving Bathurst Correctional Officers to use on Lathan) raises questions about the application of the policy. Moreso, in circumstances where the "Transport to Hospital or other place specified order" document authorising Lathan's transfer to the hospital (a) directed he be restrained unless Governor approval for removal was obtained and (b) did not refer to part [2.2] of the policy.

124 She submitted that the "Transport to Hospital or other place specified order" document should be reviewed so that the effect of Part [2.2] of the policy is included on the form and that, where such a decision is made, it is clearly communicated to relieving escort staff.

125 The Commissioner has again recognised the strength of Ms Mackay's submission and indicated the document will be reviewed and amended to include the effect of Part [2.2] of the policy.

Early Release from Custody

126 Another matter that attention was drawn to during the inquest was a reference in progress notes made by Dr Eliza Metz, resident medical officer at Orange Hospital of a conversation she had with the Justice Health After Hours Nurse Manager (AHNM) concerning potential steps that might be made in relation to an application for Lathan's early release from custody given his dire health status.

127 There is specific reference in the note to Lathan being released to freedom so his death is not a death in custody.

128 As a result, a letter was provided to the Court on behalf of Justice Health setting out an understanding of the intention behind the communication between the AHNM and the doctor at Orange Hospital. In short, it is said that this arose as a result of Justice Health's statutory obligation under Reg 285 of the *Crimes (Administration of Sentences) Regulation* 2014 to notify Corrective Services NSW when an opinion has been formed that because of an illness, an inmate will not survive their sentence.

129 The letter sets out the terms of s160 of the *Crimes (Administration of Sentences) Act 1999* (the Act) which provides for the potential release of an offender on parole by order of the Parole Authority, where an inmate is dying. The letter also attaches a copy of Justice Health's policy 1.170 *Mandatory Notification for Life Limiting Illness and Permanent Disability* dated June 2022.

130 It does not appear that there would have been any possibility for Lathan to have sought such early release, given that he was not serving a sentence of imprisonment. Rather, he had been remanded in custody because of a detention application under the *Bail Act*, pending his matters being dealt with further in the Local Court. Although Reg 285 appears to require the provision of a report in the case of both sentenced and unsentenced prisoners, it does not appear that s160 of the Act can have application to unsentenced prisoners.

131 On this issue, Justice Health submitted there is a "legislative drafting discrepancy" between the Act and the Regulation but that an observation about a review of the policy is ultimately unlikely to be of any meaningful benefit in circumstances where the regulation requires provision of a report in the case of both sentenced and unsentenced prisoners (notwithstanding section 160 of the Act).

132 It was further submitted that an adjustment to the policy could not be expected to deal with the "legislative drafting discrepancy" and that, as consideration of the issue is necessarily reliant on inferences being drawn from hearsay evidence, the matter required more substantial exploration before it receives judicial treatment. The ultimate submission of Justice Health was that the topic was irrelevant.

133 I do not accept the submissions of Justice Health on this issue.

134 Firstly, any suggestion that Justice Health's statutory obligations and related policy might have been used to avoid Lathan being recorded as a death in custody (more so, an Aboriginal death in custody), is morally repugnant. It is clearly a serious and entirely proper concern for Lathan's family.

135 Having said that, *the evidence before me does not permit the suspicion (yet alone a conclusion) that this was the case*.

136 Secondly, whilst it might be relevant to the weight given it and should be approached with some caution because of it, the hearsay nature of the evidence is no basis, of itself, not to deal with an issue where it legitimately arises in these proceedings.

137 Thirdly, whilst I accept that the evidence on the issue is limited and was not central to the issues explored at inquest, it is difficult to conceive what further evidence might be thought necessary given the issue arises from the terms of the Regulation, the Act and the policy themselves.

138 Fourthly, I do not accept that a “legislative drafting discrepancy” makes it inappropriate for Justice Health to consider a review of policy 1.170 (so far as it appears to imply that s160 may apply to unsentenced inmates) when *s160 of the Act can have no application to unsentenced prisoners*.

139 Having said that, I will not make a formal recommendation in the absence of a specific submission from Counselling Assisting or Lathan’s family inviting me to do so.

Issue: Was the health care provided to Lathan in the period following his entry into Corrective Services custody on 5 December 2023 adequate and in compliance with policy and should any underlying condition have been detected prior to his death?

140 The starting point for consideration of this issue must be a recognition that Lathan’s involvement with health care services at Wellington Correctional Centre in the month that he was in custody prior to his death was limited.

141 It must also recognise the conclusion already reached in these findings that Ms Byrne mistakenly recorded Lathan’s measurements on 5 December 2023 and that she was *not* under the impression Lathan’s weight was 48kg or that he had

a concerning BMI. Consequently, the uncertain nature of her compliance with requirements to take a repeat observation and consult with her Nurse in Charge do not arise.

142 Recent reports made by the Inspector of Custodial Services that specifically relate to health care services of Aboriginal inmates at the Centre also provide some context to this issue. I note in particular:

(1) The Inspector of Custodial Services March 2021 report "Health Services in NSW Correctional Facilities" records in 2021, 62% of prisoners at Wellington Correctional Centre's maximum security facility, where Lathan was being held, were Aboriginal, at that stage the second highest proportion in the state after Tamworth.

(2) A 2022 report by the Inspector concerning Wellington Correctional Centre recommended that Justice Health ensure regular access to inmates by Aboriginal Health workers.

(3) Consistent with this, the 2021 Report had recommended that Justice Health "staff all correctional centres with Aboriginal and Torres Strait Islander Health Workers/ Practitioners and identified Aboriginal health staff and collaborate with relevant peak bodies regarding clinical and cultural support." It also recommended that Justice Health "continue to explore partnerships with Aboriginal Medical Services and funding models to support provision of culturally safe primary health care."

143 It was not suggested that the challenges that Justice Health may have in providing such access played a role in Lathan's death but Lathan's inquest provided a modest opportunity to gauge the extent to which Justice Health has been able to address the recommendations of these reports with a view preventing future potential deaths.

144 With those things in mind, A/Prof Adams' evidence on the health care provided to Lathan in the period following his entry into Corrective Services custody was:

(1) The most effective way of preventing sudden unexpected cardiac death in a person such as Lathan is through preventative health screening.

(2) Lathan was noted as being 165cm tall on 5 December 2024. If he weighed 60kg at the time of his reception screening this gives a BMI of 22.0/kg sqm. At post-mortem his weight was assessed at 64kg with a BMI of 22.4/kg sqm.

(3) Both of these BMI measurements are within the normal range and he suspects Lathan was slim rather than malnourished (an observation consistent with evidence that Lathan was a good eater). This weight range likely did not play a significant role in his death.

(4) Lathan's blood pressure on reception screening was 97/59 mmHG. That is within the normal range for a person his age. It was not a finding that was of concern or that necessitated follow up – particularly as over the next few weeks Lathan was able to play touch football for reasonable periods of time.

(5) Lathan's low blood pressure was unrelated to his drug use. In fact, methamphetamine would be more likely to cause hypertension.

(6) Because Lathan was under 30 years old, physically active, not overweight and screening tests were all re-assuring, there was no clinical indication to perform an echocardiogram at any point during his incarceration or before that time.

(7) A physical examination would not likely have detected Lathan's mitral valve prolapse. Even if it had been detected, intervention would not have been indicated other than perhaps a follow up

echocardiogram at 2 yearly intervals. In other words, it would not have led to any measures that would have prevented his death.

145 The inquest went on to explore to some degree the availability of preventative health screening to inmates at WCC, particularly young Aboriginal inmates such as Lathan and Justice Health's Director of Nursing (Regional), Ms Deb Little, gave evidence on the issue.

146 She agreed that health screening policies referable to Aboriginal inmates at a service wide level had changed as of late 2023. The June 2023 version of Justice Health's policy "*Health Assessments in Male and Female Adult Correctional Centres and Police Cells*" provided for screening for chronic conditions for inmates with a confirmed chronic condition, Aboriginal inmates over the age of 45, and otherwise, inmates over the age of 55.

147 The December 2023 version of the policy removed the age based screening element and replaced it with a "chronic condition assessment", to be conducted within 30 days of the reception of an inmate." At the same time, a new "preventative screening model" was introduced. The policy notes that patient groups targeted for such screening should be seen at the frequency of once every 12 months, in the case of Aboriginal and Torres Strait Islander inmates, and once every 2 years in the case of patients 55 years of age and older.

148 In particular, the policy provides that "*if a patient is within the Preventive Health Screen target groups at the time the RSA is completed the patient must be placed on the 'Preventive Health Screen' waiting list on PAS including a 'see by' date. The patient should have a Preventive Health Screen completed in JHeHS 12 months post their RSA. A PAS Alert is added to the patient's health record 'Preventive Health Screen Program*'.

149 The policy further states that such preventative screening "*can be opportunistic, it does not need to occur on its own, for example it can be added on to an existing appointment when the patient is presenting for other health care needs. Or it can be completed as an appointment on its own.*"

150 In Lathan's case, a Patient Administration System (PAS) entry records that on 3 January 2024 Lathan had been placed on a waitlist to be seen by an Aboriginal Health Worker for "Aboriginal Chronic Care Program (ACCP) cultural support". Ms Little was asked what an appointment of this nature was in the context of relevant policies. In oral evidence Ms Little said that she considered that the appointment would have involved screening under the new preventative screening model.

151 She indicated that the reference to ACCP cultural support had been used by Justice Health on a longstanding basis, but it could equally have referred to preventative screening. She indicated that the "cultural support" element reflected "making sure, being a young Indigenous patient's first time in custody, that an aboriginal health worker would've assessed him / checked him."

152 While it is encouraging that there appears to have been recognition of the appropriateness of Lathan seeing an Aboriginal Health Worker for that purpose, the evidence reflected the fact that it remains very challenging for Justice Health to deliver such appointments to Aboriginal inmates at Wellington Correctional Centre.

153 Justice Health is clearly making efforts towards providing services and staffing to specifically address the health circumstances of Aboriginal inmates. Those efforts include:

(1) Multiple rounds of recruitment in relation to the Aboriginal Health Worker position at Wellington Correctional Centre.

(2) A longstanding formal partnership with Waminda South Coast Women's Health and Welfare Aboriginal Corporation (Waminda) to deliver the Aboriginal Family Health Worker program. This program assists Aboriginal women in custody, at the point of reception into custody and transition back to community, across New South Wales.

(3) As at the date of Ms Little's statement, an expansion of this program had been approved and funded for implementation at Wellington Correctional Centre to provide a similar in-reach model to both male and female inmates and Justice Health NSW was developing the relevant contracts and an implementation plan. It was expected Wellington Correctional Centre would have four Aboriginal Family Health Workers – two for male inmates and two for female inmates.

(4) Aboriginal Health Workers from other correctional centres have been attending Wellington Correctional Centre intermittently on an 'as needs' basis.

(5) In 2024, Justice Health reallocated funding to create two senior Aboriginal Healthcare positions to work within the Primary Care directorate – the Service Director Aboriginal Health and the Clinical Director Aboriginal Health.

(6) The Service Director Aboriginal Health monitors the Aboriginal Health Worker waitlist at Wellington Correctional Centre [and Statewide] to ensure Aboriginal Health Worker coverage statewide can be achieved as best as possible, with the current resources available. The Service Director is local to the Wellington area and has a regular presence within Wellington Correctional Centre.

154 From Ms Little's evidence it is also clear that over the last 18 months Justice Health has:

(1) appointed numerous senior Aboriginal leaders, including the inaugural Service Director Aboriginal Health and Clinical Director Aboriginal Health;

(2) established the Aboriginal Health Strategy Committee which reports directly to the Justice Health Board;

(3) established the Aboriginal Staff Council;

(4) established the Aboriginal Community Advisory Council – consisting of representatives from the Aboriginal community;

(5) redesigned numerous senior clinical positions as Aboriginal-identified roles, resulting in increased Aboriginal workforce representation;

(6) established partnerships with Aboriginal Medical Services to enable culturally appropriate in-reach services to be provided to Aboriginal people in custody; and

(7) introduced Aboriginal Health Practitioner roles in health clinics, thereby ensuring more face-to-face support for Aboriginal patients by Aboriginal health staff.

155 Notwithstanding the totality of Justic Health's efforts referred to in [153]-[154], there remain significant challenges in filling Aboriginal Health Worker positions in the context of inmate primary care. No doubt the willingness of applicants to work in a custodial environment is a challenging factor as Ms Little suggested.

156 At the time Lathan was in custody it appears that the sole Aboriginal Health Worker at WCC was, for most of the time, on extended personal leave, and that the position subsequently became vacant. It remains vacant (although I note the submission that further interviews were conducted in July 2025 and that a preferred applicant has been identified).

157 As of 29 May 2025, when Ms Little gave evidence, she reported that there were 12 full time equivalent (FTE) Aboriginal Health Worker positions in Justice Health. Only four of these positions were filled. In addition, there were two ATSI identified enrolled nurse positions that were filled.

158 Ms Little was asked whether the absence of an Aboriginal Health Worker made the delivery of preventative health program at Wellington difficult. She observed that the program can be delivered by nursing staff, but that it is culturally appropriate for an Aboriginal Health worker to be part of the process.

159 The inference to be drawn from her evidence is that whilst Justice Health is committed to continuing to build its Aboriginal workforce, provide holistic, safe and appropriate models of care and service delivery to Aboriginal patients, and to connect and work collaboratively with external organisations to maximise potential and optimise patient health outcomes (as was submitted) the provision of the program at Wellington in a culturally appropriate manner has not been possible in the absence of an Aboriginal Health Worker.

160 The inquest did not seek to engage in an assessment of the efficacy of the preventative screening model introduced by Justice Health. On its face, if capable of effective implementation, it appears to be a positive development that may assist in the early detection of chronic conditions in younger Aboriginal inmates.

161 The implementation of the model in a culturally appropriate manner clearly faces significant challenges, however, given the difficulties encountered by Justice Health in filling Aboriginal Health Worker positions, including at Wellington.

162 As Counsel Assisting urged, I am not critical of Justice Health in this respect. The lack of resources available at Wellington and the limited number of Aboriginal Health Workers currently available more generally are, however, matters appropriate to document in these findings particularly as the quality and nature of provision of health services to First Nations inmates are matters that have been identified as areas of concern by the Inspector of Custodial Servies in reports of the type referred to above.

163 As regards Ms Mackay's recommendation that Wellington Correctional Centre investigate further ways to broaden its partnership with Aboriginal medical

services (generally, as I understand the submission) I agree that the suggestion, which is oriented toward strengthening culturally appropriate treatment is commendable and aligned with Justice Health efforts to date and its aims for service delivery. I see no reason why, independently of this inquest, that could not be explored.

164 Having said that, I also agree that in the context of Ms Little's evidence and the absence of evidence concerning the capacity and inclination of Aboriginal medical services generally (or Wellington Aboriginal Corporation Medical Service and Waminda South Coast Women's Health Service specifically) to be more greatly involved, it would be inappropriate to make the matter the subject of a formal recommendation pursuant to s82 of the Act.

Issue: Was Lathan's death preventable?

165 Although the adequacy of the emergency responses at Wellington and Orange Hospitals was not explored in oral evidence, A/Prof Adams' evidence as to whether Lathan's death was preventable was:

(1) Wellington medical staff spoke with the intensive care unit and the on-call cardiologist at Orange Hospital before making the decision to transfer Lathan to Orange Hospital. That was very reasonable given the lack of resources and cardiac facilities at Wellington Hospital relative to Orange Hospital. The consideration for a medical retrieval to Sydney to support Lathan was a more than adequate response.

(2) At Orange Hospital Lathan was assessed by emergency physicians, intensive care physicians and a cardiologist who performed an ECG but Lathan had no response to treatment. His prognosis was dire and his chances of survival were close to zero. Had he survived he would have had profound hypoxic brain injury. In those circumstances the decision to cease supportive treatment was entirely appropriate.

(3) Sadly, the chances of surviving a sudden cardiac arrest (like what happened to Lathan) in a non-hospital setting are very small: something like only 8% and many of those that do survive are left with significant disabilities. A/Prof Adams goes onto say that even if a cardiac arrest happens in hospital the overall survival rate to discharge from hospital is less than 23%.

166 A/Prof Adams also gave evidence on why, despite Lathan's poor condition at the Correctional Centre, intrusive efforts were subsequently made to save him: efforts that ultimately frustrated his family seeing Lathan before he died.

167 A/Prof Adams said this was done because Lathan was young and treating doctors, faced with uncertainty on how long there had been ineffective cardiac function and whether hypoxic brain injury had been caused, wanted to try everything they could because survival (at least initially) is unpredictable and even in cases that appear without hope, a patient has been known to recover. He said those same considerations informed the decision of medical staff to transfer him to Orange.

168 I accept the conclusions of A/Prof Adams concerning these issues. *Sadly, Lathan's tragic and unexpected death was not preventable*. This conclusion takes into account both the emergency response on 6 January 2024 and the adequacy of health care provided to Lathan following his entry into Corrective Services NSW custody on 5 December 2023 as previously discussed.

Issue: In relation to the medical emergency on 6 January 2024, was communication by Corrective Services Officers with family members adequate?

169 The matter of most concern that arose in this case was the manner in which Lathan's condition and circumstances were communicated to family members during the course of the afternoon and evening of 6 January 2024. I note in particular what Lathan's father had to say about this issue:

> "I did not get to see my son Lathan alive one last time, this opportunity was robbed from me because we had been told earlier in the night that he was being transported to Dubbo Hospital when this wasn't the case and by the time we got to Wellington Hospital he was getting ready to be airlifted. Lathan was not left alive on life support until I got to see him. Lathan passed away without his family being with him and this is still deeply horrifying and upsetting to me"

170 The evidence establishes that Lathan was received into the Emergency Department (ED) at Wellington Hospital at approximately 4.56pm. At around that time SAS Bolden contacted Ms Mackay, as Lathan's "Emergency Contact Person" (ECP).

171 That contact was consistent with Custodial Operations Procedure and Policy (COPP) 13.2, "Medical Emergencies". Part [2.2] of COPP 13.2 provides that:

> An inmate's Emergency Contact Person (ECP) must be informed if an inmate is taken to hospital with life threatening injuries and it is obvious he or she will be admitted (e.g.massive head trauma, stab wounds).
>
> …
>
> An ECP must be further notified if an inmate inpatient's:
>
> • medical condition deteriorates and becomes life threatening; or
>
> • hospital stay is extended beyond the initial hospital discharge date.

172 The phone call made by SAS Bolden appears to have been the only phone call made by any CSNSW officer (other than escort officer Cubillo) to any family member, prior to Lathan's death.

173 Responsibility for the communicating with the ECP falls to the Governor or OIC. At this stage SAS Bolden and SCO Serone appear to have assumed joint responsibility as OIC's for the incident (SAS Bolden, who was staying on having

been the OIC of the “A” shift, was the most senior officer present at the Centre and SCO Serone was the officer in charge of the “C” shift that had commenced at 4pm).

174 In oral evidence SAS Bolden explained that she obtained Ms Mackay’s phone number by logging in to the Offender Information Management System (OIMS), where Ms Mackay’s phone number was recorded as Lathan’s next of kin. She further indicated that she had to seek special permission from the Governor to make this contact prior to Lathan’s admission to Hospital.

175 In seeking this dispensation, it appears that SAS Bolden recognised that Lathan’s health status was particularly dire, and that a departure from her standard practice was necessary in the circumstances. SAS Bolden said in evidence that Lathan’s condition was “already life threatening” (in reference to the policy reference to the need to contact the ECP if a patient’s condition deteriorates), and that Ms Mackay informed her that she would contact Lathan’s father and that they would get in touch with the hospital. SAS Bolden said that she let Ms Mackay know that approval was given by Corrective Services for family visits, but that she was unsure what the Hospital’s policy was.

176 SAS Bolden said that other than COPP 13.2 she was not aware of any other policy that was relevant to the degree of engagement that Corrective Services should have with family members in such circumstances.

177 She further stated that in conducting her responsibilities to report to senior officers in relation to the medical emergency, she was acting pursuant to COPP 13.1, titled “Serious Incident Reporting”.

178 Part [2.7] of COPP 13.1 outlines a range of “Communication, liaison and administration duties” that fall to the Governor or OIC when a serious incident occurs at a Correctional Centre. It provides that the Governor or OIC may appoint a correctional officer to the role of “liaison officer”, to liaise directly with police, emergency services, CSNSW investigators, JH&FMHN and any other relevant services.

179 The provision makes no reference to family members of an inmate the subject of a serious incident in the context of the “liaison officer” role.

180 Returning to what happened on 6 January 2024, at around 6pm SAS Bolden received a call from a family member, Uncle Ray, seeking an update in relation to Lathan’s condition. SAS Bolden recalls informing “Uncle Ray” that Wellington Hospital would not allow visits, that Lathan’s transfer to Dubbo Hospital was pending, and that he should contact Dubbo Hospital to see if they would allow a visit. In oral evidence she thought it likely that officer Mullen was the escort officer who had advised her that Wellington Hospital would not allow visits.

181 As a result of receiving information via Ms Mackay (from his daughter Claudia), Lathan’s father, Michael Brown, was made aware that Lathan was at Wellington Hospital and was going to be transferred to Dubbo Hospital, where other family members were waiting. Michael was in Orange and immediately drove to Dubbo Hospital, a trip of around 1 hour and 45 minutes, and which took him through Wellington. It seems likely that Michael would have left Orange in the vicinity of 6pm and would have arrived in Dubbo shortly before 8pm.

182 The next contact that appears to have involved family resulted from a call made by Ms Mackay to Wellington Hospital at around 8.45pm. Lois was put on to the escort guard, SCO Michael Cubillo. Officer Cubillo recounts that Lois asked him when Lathan was going to be transferred to Dubbo, and was advised that he was now going to be transferred to either Orange or Sydney. Officer Cubillo took Lois’s number and advised her that he would get back to her once the transfer location was known.

183 Officer Cubillo recounts that he called Lois’s number at 8.59pm and spoke to a younger female relative, informing her that Lathan would be transferred to Orange. The relative informed officer Cubillo that Michael Brown would travel to Orange to see Lathan. In the course of the call a paramedic at Wellington Hospital asked to speak to the family member, informing her that Lathan was “seriously ill” and “unlikely to survive”.

184 Shortly thereafter officer Cubillo made a further call to the family member to advise her that he was aware of a road closure that would affect travel to Orange and gave advice as to the best road to take. This appears to have been the last contact between a Corrective Services NSW officer and any family member prior to Lathan's death.

185 Michael Brown drove from Dubbo to Orange in an effort to see Lathan. En route he stopped at Wellington Hospital but was advised that he could not see Lathan due to "security" and that Lathan was getting ready for transfer to Orange. It appears likely that this would have occurred at around the time that the retrieval team was in the process of putting the transfer into effect (in the vicinity of 9.30pm). Michael travelled on to Orange, arriving at Orange Hospital at around 11.25pm, by which time Lathan had passed away.

186 Contrary to various records that appear in Corrective Services NSW documentation, no family member did get to see Lathan prior to his death at 11.15pm. Contrary to the actual position, *incorrect* references appearing in CSNSW documentation include the following:

(1) A reference in the serious incident briefing note made by SAS Bolden at 9.15am on 7 January 2024 that "BROWN was kept on life support until his family members could attend. Life support was withdrawn and BROWN passed away around 1.05am 07/01/2024."

(2) A reference in the Report of Troy Brien, Acting Manager of Security for WCC dated 8 January 2023 that "At approximately 22:00 hours inmate BROWN's family were permitted to visit inmate BROWN at Orange District Hospital as Hospital staff advised that inmate BROWN is not likely to survive."

(3) A reference in the report of Lennox Peter, Acting Governor of Wellington Correctional Centre on 8 January 2024 that "Inmate

BROWN's family was present when medical staff pronounced time of death at 11:15pm".

187 It is further noted that the Corrective Services Investigator responsible for the review and investigation of the death, Mr Paul Sheehan, remained under the impression that family members were present at Orange Hospital at the time of Lathan's death both when concluding his report in March 2024, and when giving evidence at the inquest on 30 May 2025.

188 It is also noted that SAS Bolden's Incident report asserts that Escort Officer Mullen had told her that "BROWN was 'brain dead' and that the inmate 's father was enroute to Orange to see him, after which the life support would be turned off."

189 In her statement SCO Serone makes a similar assertion – that Officer Mullen told her that "they were going to fly the inmate to Orange and keep him on life support until his father arrived at the hospital to see him, and then they were going to switch it off."

190 The suggestion that there was any "arrangement" in place such that the withdrawal of life support would not take place until Michael Brown or other family members were able to see Lathan is not supported by the evidence. Neither of the escort officers who gave evidence suggested that such an arrangement had been put in place or that they had communicated this to SAS Bolden or SCO Serone.

191 The only suggestion that any Corrective Services officer had communicated any information to a clinician suggesting that family members were on their way to see Lathan came from Officer Cubillo in his oral evidence. Although not referred to in his statement, in his oral evidence Officer Cubillo said that he made the comment to a clinician, at a point when he understood that Lathan was still alive, that "Lathan's father was on his way." According to Officer Cubillo, at the time hospital staff were drawing curtains around Lathan.

192 Officer Cubillo indicated that this occurred about 10 minutes before the arrival of Bathurst officers, (which occurred at 11.25pm), thus suggesting that it took place around the time that Lathan is known to have passed away.

193 Although Officer Cubillo made a positive impression on me as both a proactive and compassionate officer, there is no reference to this conversation in the Hospital's clinical notes and relevant clinicians were not called to give evidence. It follows that his evidence should be treated with some caution. If officer Cubillo's recollection in this respect is correct, it appears that the comment was made at or about the time that Lathan's life support had been withdrawn, and that it may in any event have come too late to have been acted on in any way.

194 Another anomalous aspect of the evidence concerning CSNSW's role in relation to family communication concerns a reference by SAS Bolden in her incident report that SCO Serone had been talking with family members but that with the Governor's approval NSW Police had taken over the role of "family liaison" during the afternoon/evening. I am satisfied those things did not take place.

195 SCO Serone herself did not suggest that she had any contact with family members during the course of the incident. Nor does the evidence support the suggestion that this process of transfer of responsibility for family liaison had taken place.

196 In her oral evidence SAS Bolden could not recall the basis for stating this in her incident report, other than thinking that SCO Serone must have mentioned it to her and that she had discussed the matter with SCO Serone prior to giving evidence.

197 Returning to the issue of communication generally, the oral evidence of a number of witnesses lends support to the view that the roles and responsibilities of Corrective Services officers for updating families with relevant information in circumstances such as Lathan's should be addressed through policy in order to assist family members, this included:

(1) SAS Bolden, in answer to questions of Ms Parker concerning the potential role of a designated escort officer;

(2) SCO Serone agreeing that more could have been done to reach out to family members on the evening and providing them with updates in a more proactive manner. She suggested that this role could have been assigned to a particular individual. She was doubtful that this role should be given to an escort officer, as their level of seniority is variable;

(3) Officer Paul Mullen, who was one of the escort officers, gave evidence that he assumed that one of the purposes of his regular updating of senior officers at Wellington Correctional Centre was for the purpose of those officers in turn being able to update the family;

(4) In answer to questions from Mr Wilcox, Investigator Sheehan supported the view that regular updates should be provided to family members in certain circumstances in order to relieve potential anxiety felt by family concerning the inmate's condition and the status of hospital transfer decision-making, even though the status of any transfer may remain unclear.

Conclusions about communication by Corrective Services Officers with family members

198 Counsel Assisting submitted in favour of the following conclusions:

(1) It is clear that Lathan's medical condition was grave and prognosis poor throughout the emergency response. There no doubt would have been challenges involved in facilitating a family visit to him at certain points during his care between 5pm and his death at 11.15pm given the degree of active medical treatment that clinicians were engaged in. The small size of Wellington Hospital and limited staff involved on the ground in

Lathan's care while at Wellington Hospital may also have been relevant in the circumstances.

(2) Notwithstanding this, considerably more could have been done to reach out to the family proactively and keep them updated in relation to Lathan's condition and potential movements, and to endeavour to help facilitate a visit prior to Lathan passing away. Regrettably, at least in the phone call made to Uncle Ray at around 6:00pm, the onus was put on the family to attend to these things in a time of great stress.

(3) There was not any failure to comply with existing policies Corrective Services polices in their present form but those policies are not well adapted to the particular circumstances that applied in Lathan's case.

(4) The inaccurate and anomalous aspects of relevant Corrective Services records and reports referred to above concerning the "family liaison" matters, appear to reflect the fact that current policies are not well adapted to provide practical assistance to families at a time of great stress for them. While it can not be certain whether a successful visit to Lathan could have been undertaken prior to his death given his precarious health and the dynamic decision-making relating to his transfer (to Sydney, Dubbo or Orange hospitals), it may well have been possible had there been a clear process in place for family liaison.

(5) Circumstances as dire as those facing Lathan would seem to be relatively uncommon and therefore the adoption of a relevant policy change should only impact a limited number of events faced by CSNSW.

199 The submissions are not controversial.

200 Counsel Assisting further submitted that the most appropriate change to policy might be in COPP policies 13.1 and 13.2 concerning serious incidents and medical emergencies (as opposed to policies applying generally to medical escorts), noting that the serious incidents policy already provides for the specific

appointment of a “liaison officer” in relation to certain matters arising from serious incidents, and the medical emergencies policy includes provisions that relate to contact with an emergency contact person.

201 The specific recommendation proposed by Counsel Assisting on this issue is in these terms:

> That either COPP 13.1 or COPP 13.2 be amended by the inclusion of a policy that addresses the following:
>
> a) A requirement for the appointment by the Governor or OIC of a sufficiently senior correctional officer or other staff member as a “family liaison officer” in circumstances where the death of an inmate transferred to a hospital arising out of a serious incident may be imminent;
>
> b) Provides that the role of family liaison officer is to include:
>
> i. being an ongoing point of contact for family members in relation to the inmate’s condition, any planned transfers and arrangements for visiting the inmate;
>
> ii. maintaining contact with hospital staff and escort officers in order to provide assistance and information to family members concerning matters referred to in (i); and
>
> iii. otherwise helping facilitate contact and arrangements between hospital staff and the inmate’s family.

202 Ms Mackay joined in that submission with additional reasons (see below) and the proposal that the role of family liaison officer include facilitating contact between hospital staff and the inmate’s family concerning end of life decisions.

203 Lathan's father made the submission that, as Lathan remained in the custody of Corrective Services, its officers on medical escorts ought to be able to act professionally and provide updates to family – particularly as to hospital locations.

204 In support of that submission, he noted the willingness of Officer Mullen to make such calls had he been directed to do so by a superior officer and that appointing someone from the medical escort to perform this role would minimise the risk of misinformation being provided to the family because they would receive it firsthand.

205 He proposed a recommendation to the Commissioner in the following terms:

206 Dealing firstly with Counsel Assisting's proposed recommendation, the Commissioner for Corrective Services NSW submits COPP 13.1 "Serious

incident reporting" makes clear that it is directed to "internal reporting processes", rather than external reporting, including to an inmate's family. Furthermore, a "serious incident" is relevantly defined under COPP 13.1 as a death in custody, a serious assault or a serious injury. Accordingly, there may be cases where an inmate is transferred to hospital when death may be imminent but does not arise from a "serious incident".

207 The submission continues that, as a consequence:

(1) COPP 13.1 is not the appropriate vehicle for any proposed recommendation;

(2) Any recommendation should not refer to a "serious incident"; &

(3) The Commissioner supports a recommendation to amend COPP 13.2 "Medical emergencies" albeit in the following, more limited terms:

"That COPP 13.2 be amended by the inclusion of a policy that addresses the following:

a) A requirement for the Governor or OIC to delegate a sufficiently senior correctional officer or other staff member to liaise with the ECP in circumstances where the death of an inmate transferred to a hospital may be imminent."

208 The Commissioner anticipates that the proposed recommendation could result in a procedural step being added under part [2.2] of COPP 13.2 to ensure that the Governor or OIC or delegated officer must provide the inmate's Emergency Contact Person (ECP) with a contact name and telephone number of a medical professional at the hospital or medical facility to enable the ECP to have a point of contact with them for ongoing communication.

209 The Commissioner does not support Counsel Assisting's proposed definition of the role of "family liaison officer" (or "delegated officer" if CSNSW's proposed terminology is adopted). Specifically, the recommendation that the role of the

delegated officer should include being an ongoing point of contact for family members in relation to the inmate's *condition*.

210 In support of that position the Commissioner accepts that COPP 13.2 part [2.2] requires the Governor or OIC to notify an inmate's ECP if the inmate's medical condition deteriorates or becomes life-threatening but notes that Corrective Services officers are not informed of an inmate's medical condition when an inmate is hospitalised (as per the MOU provided by Justice Health) and that the requirement is dependent on such information being conveyed to Corrective Services by health staff.

211 The Commissioner argues that, consequently, Corrective Services is limited in the extent to which it would be able to convey information about an inmate's medical condition to their family. Further, in Lathan's case specifically, Corrective Services officers were not made aware that a decision to cease resuscitation efforts had been made by hospital staff, nor that Lathan had passed away, until some time after the fact.

212 The Commissioner *does* support the delegated officer being an ongoing point of contact for an inmate's ECP including in terms of any planned transfers and asserts that if such a change in policy were in place at the time of Lathan's death it would have made clear to the OIC at Wellington that they were obliged to keep Lathan's family informed of any planned transfers as they developed, and may have led to more timely information about where Lathan may or may not have been transferred to being communicated to his family.

213 In terms of visiting arrangements, the Commissioner submits these are comprehensively covered by COPP 19.6 "Medical escorts", specifically part [6.2] "Visits", that the Governor or OIC would be familiar with COPP 19.6 and would be in a position to provide an inmate's ECP with information about hospital visits in accordance with that policy and thus there is no need for a specific recommendation to update COPP 13.2 to duplicate the Governor or OIC's function with respect to hospital visits as provided by COPP 19.6.

214 The Commissioner further submits that it was clear from the evidence of the escort officers that they understood that they were obliged to regularly report any developments during Lathan's hospitalisation to the OIC at Wellington. It is therefore unnecessary for any recommendation to be made to the effect that it is part of the family liaison officer's role (the Governor or OIC) to maintain contact with escort officers – any relevant information supplied to escort officers by health staff are promptly communicated to the Governor or OIC.

215 The Commissioner does support a further description of the role of the delegated officer to "otherwise facilitate contact and arrangements between hospital staff and the inmate's family", particularly noting that it is health staff who are best placed to provide up-to-date and timely information about an inmate's medical condition, and any measures by which a Governor or OIC can facilitate such contact as the delegated officer are clearly desirable.

216 Turning then to Mr Brown's proposed recommendation, the Commissioner does not support it. The submission is that it would have the practical effect of appointing an escort officer as family liaison officer, rather than the Governor or OIC and about that the Commissioner submits:

(1) Furthermore, the s24(1) "Transfer to hospital or other place specified order" in Lathan's case included Ms Mackay's name and number as Lathan's ECP. They did not have Mr Brown's contact details and do not have access to *other* family contact details as a matter of course.

(2) It is not possible for there to be a Senior Correctional Officer as OIC on every escort where an inmate is hospitalised with life-threatening injuries. Escort staffing needs to consider the ongoing operations of the correctional centre concerned, and staffing decisions are made based on the necessary experience of available staff when planning escorts. For example, there could be occasions where the only available Senior

Correctional Officer is fulfilling duties as night senior (OIC of the centre). There may be similar staffing issues during day shifts, especially in remote centres. It is preferable that the Governor or OIC perform the role of family liaison officer in these circumstances for the reasons given above.

217 The Commissioner's submissions are, for the most part, compelling.

218 The recommendation I make is in these terms:

That COPP 13.2 be amended by the inclusion of a policy that addresses the following:

(a) A requirement for the Governor or OIC to delegate a sufficiently senior correctional officer or other staff member to liaise with the ECP in circumstances where the death of an inmate transferred to a hospital may be imminent.

(b) The Governor or OIC or delegated officer must provide the inmate's Emergency Contact Person (ECP) with a contact name and telephone number of a medical professional at the hospital or medical facility to enable the ECP to have a point of contact with them for ongoing communication.

(c) The Governor or OIC or delegated officer being an ongoing point of contact for an inmate's ECP including in terms of any planned transfers.

(d) The Governor or OIC or delegate must otherwise facilitate contact and arrangements between hospital staff and the inmate's family.

Issue: Communication by Hospital staff with family members

219 Following the conclusion of oral evidence, CSNSW and NSW Health were requested to provide further policies of potential relevance to the question of family engagement of those agencies in circumstances such as Lathan's.

220 One of the documents provided by NSW Health was a "Frequently Asked Questions" (FAQ) document relating to its "Memorandum of Understanding" with Corrective Services. In relation to the question "Can I contact the patient's next of kin/emergency contact?" (which is evidently being posed from the perspective of a NSW Health clinician or other staff member), it advises:

> "Under **no circumstances should a custodial patient's next of kin or emergency contact person be contacted** without the approval of the escorting CSNSW officer, for strict security and safety reasons." (bold in original)

221 The FAQ document further advises that in response to an enquiry being made by another person as to whether a custodial patient is being cared for in a particular hospital, that "this information must not be disclosed to another person, even if they seem like they know the custodial patient well. The unapproved disclosure of this information can lead to a significant security breach."

222 The need for such stringent advice is self-evident.

223 Whilst I deal with this issue it is appropriate to deal with Ms Mackay's submissions that:

(1) In circumstances where the family arrived within 3 minutes of infusions and ventilation being ceased, it may well have been possible to keep life saving measures in place (were the staff aware of the family's presence);

(2) Even if this were not possible, it would have been appropriate to have some communication with the family around this decision; and

(3) The policies in place for correctional centre inmates may inhibit reasonable communication with family members around important health decisions and this is another reason to adopt the submission of Counsel Assisting recommending a "family liaison officer".

224 On the first of these matters Ms Mackay and her family agree that the decision made to cease supportive treatment was, in itself, appropriate given Lathan's condition. The issue she raises for consideration is *when* that should have happened in Lathan's case.

225 About that there is simply insufficient evidence before me. The statements from doctors involved (including that of Dr Fitzpatrick referenced in her submissions), the Orange Health Service clinical records and the evidence of A/Prof Adams that "keeping Lathan alive" until such time as his family were able to see him "is not straightforward" make that clear.

226 On the second and third of these matters Ms Mackay makes reference to the FAQ document identified in [220]:

> "Under **no circumstances should a custodial patient's next of kin or emergency contact person be contacted** without the approval of the escorting CSNSW officer, for strict security and safety reasons." [Emphasis in the original]

She also refers to the statement of Dr Greg Button that:

> "The clinical records do not indicate that there was any discussion between medical / nursing staff and Mr Brown's family. While hospital staff would normally contact next of kin in emergency situations where the next of kin is known, sometimes this is not an immediate priority in a small hospital like Wellington with limited staff. In addition, I note that Orange Hospital staff were advised that it was the responsibility of Correctives Services to notify Mr Brown's next of kin of his condition."

Next, she refers to the NSW Health Policy Directive “Using Resuscitation Plans in End of Life Decisions” document that is in the following terms:

> Using Resuscitation Plans in End of Life decisions
>
> 2.2.3 *Where the Attending Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient. [*…]
>
> A medical practitioner does not need to obtain agreement from the patient or family to withhold interventions considered to be of negligible benefit, *but it is still good clinical practice to discuss why these are not being offered in the context of broader end of life goals of care conversation*. This includes scenarios that may present at an Emergency Department. If consent is not sought, the reasons why should be documented in the patient record. It is also the case that engaging patients in such discussion does not obligate the treating team to provide treatments that they believe are considered to be of negligible benefit. [emphasis added]

Finally, Ms Mackay refers to the evidence of Officer Cubillo:

> “We kept our distance. We don’t get in the way of the staff. We don’t interfere with that. We get dirty looks if we do move into their space... When they started to close to the curtain, I said to them Lathan’s father’s on his way… I assumed he was still alive and wanted to make sure.”

227 The logic of her submissions based on this material is apparent but, as Justice Health submitted, in this inquest care must be taken to avoid any suggestion that Orange Health Service clinicians should have communicated in a different way than the evidence suggests occurred. That is because (1) neither Orange Base Hospital nor Western NSW Local Health District was a party of sufficient interest during the inquest and (2) no clinicians were called to give evidence at the Inquest.

228 It follows that the only observation I make is that, in view of the stringent advice given them, it is unsurprising that clinicians in Lathan's matter would themselves have been reticent to take initiative to contact family members.

Concluding remarks

229 I will close by conveying to Lathan's family my sympathy for the tragic loss of Lathan. I acknowledge that he is forever lost to them and that this loss is also felt by the broader community.

230 I thank the Assisting team, particularly Mr De Mars and Ms Hill for their outstanding support in the conduct of this inquest.

231 I thank the officer in charge, Detective Senior Constable Magann for his work in work in conducting the investigation and compiling the brief of evidence and finally, Nicolle Lowe, Aboriginal Coronial Information and Support Officer for all behind the scenes assistance to Lathan's family and others.

Statutory findings required by s 81(1)

232 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity of deceased:	Lathan Brown
Date of death:	6 January 2024
Place of death:	Orange Hospital, ORANGE NSW 2800
Cause of death:	Cardiac arrythmia
Manner of death:	Natural causes while in the lawful custody of Corrective Services NSW

Recommendations pursuant to s 82(1)

To The Commissioner of Corrective Services NSW:

1. That consideration be given to adopting a procedure at Wellington Correctional Centre that would require at least one incoming and one outgoing officer to be present, so far as possible, in the J Block officers' station, during the handover period between A and C watches, in order to facilitate the timely response to knock-up calls requiring an urgent response.

2. That action be taken to investigate and, if appropriate, implement measures to improve the quality of the audio from knock-up calls heard in the monitor room at Wellington Correctional Centre, including if appropriate by restoring the availability of a functioning handset, and take steps to ensure that monitor room staff are aware of the available hardware for answering knock-up calls.

3. That COPP 13.2 be amended by the inclusion of a policy that addresses the following:

   (a) A requirement for the Governor or OIC to delegate a sufficiently senior correctional officer or other staff member to liaise with the ECP in circumstances where the death of an inmate transferred to a hospital may be imminent.

   (b) The Governor or OIC or delegated officer must provide the inmate's Emergency Contact Person (ECP) with a contact name and telephone number of a medical professional at the hospital or medical facility to enable the ECP to have a point of contact with them for ongoing communication.

(c) The Governor or OIC or delegated officer being an ongoing point of contact for an inmate's ECP including in terms of any planned transfers.

(d) The Governor or OIC or delegate must otherwise facilitate contact and arrangements between hospital staff and the inmate's family.

I close this inquest.

Magistrate Stuart Devine
Deputy State Coroner
Dubbo Local Court

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